REQUEST FOR PROPOSAL
Addendum # 3

Department Of Executive Services
Finance and Business Operations Division
Procurement and Contract Services Section
206-684-1681 TTY RELAY: 711

DATE ISSUED: January 19, 2005

RFP Title:	**Electronic Health Record Management System (EHR)**
Requesting Dept./ Div.:	**Seattle – King County Department of Public Health**
RFP Number:	**102-05RLD**
Revised Due Date:	**January 25, 2005 - 2:00 P.M.**
Buyer:	Roy L. Dodman, roy.dodman@metrokc.gov (206) 263-4266

This addendum is issued to revised the original Request for Proposal, dated December 23, 2004 as follows:

1. The proposal opening date remains the same as changed via Addendum 1: **Tuesday, January 25, 2005** no later than 2:00 p.m. exactly.
2. On the second page of the document, the following instruction:

   "Submittal: King County requires the Proposer to sign and return *this entire Request for Proposal (RFP) document*,

   is amended to read:

   Submittal: King County requires the Proposer to sign and return *the cover page and all of Section I **only** of the RFP, and those tables and forms required to be responsive to the RFP.*

(continued on page 2)

TO BE ELIGIBLE FOR AWARD OF A CONTRACT, THIS ADDEMDUM MUST BE SIGNED AND SUBMITTED TO KING COUNTY

Sealed proposals will only be received by:
King County Procurement Services Section, Exchange Building, 8th floor, 821 Second Avenue, Seattle, WA 98104-1598. Office hours: 8:00 a.m. - 5:00 p.m., Monday – Friday

Company Name

Address		City / State / Postal Code
Signature	Authorized Representative/Title	
Email	Phone	Fax

This Request for Proposal – Addendum will be provided in alternative formats such as Braille, large print, audiocassette or computer disk for individuals with disabilities upon request.

The following is a revision/further clarification of a previously issued question and response included in Addendum 2:

Q47: Does King County plan on buying the client PC hardware and peripherals for the system? If not, we need an estimate of the number of PCs and peripherals needed.

A47: Yes. Refer to A9 of Addendum 2 for estimated number of PC's. The County may purchase any additional hardware directly or possibly through the EHR vendor.

The following information is provided in response to questions received:

Q1: Does the County currently have subscription relationships with third-party reference databases, i.e. Medline, PDR, etc.? If so, with whom are these relationships?

A1: Not to our knowledge.

Q2: Please provide a copy of the County's HIPAA Business Associate Agreement.

A2: We will include this during contract negotiations.

Q3: The RFP refers to a HIPAA requirement for encrypted data storage. This requirement is not contained in the security sections of HIPAA. Please clarify the reference for this requirement.

A3: The reference is in regard to HIPPA confidential patient information, such as names, date of birth, etc., that might be copied to another database that could be used for testing, training, or other external purposes. As such, this type of information must not be transported in a discernable manner, or in other words must be "encrypted".

Q4: Does the state or county have a requirement for the separation of medical and mental health information?

A4: To our knowledge this is not a state requirement. Our preferred approach is to have one integrated medical record and use system security as a means of limiting access to data on a need to know basis. If separate "physical" records become a requirement we would want to be able to "associated" them.

Q5: Please provide Washington State standards for electronic signatures. Is King County willing to consider a phased implementation?

A5: Electronic signatures for providers (e.g. orders) are required. Electronic signatures for patients is highly desirable but could be implemented at a later date.

The citation is RCW 19.34.

Q6: Is King County willing to consider a client/server architecture if provided an upgrade path to a .Net based solution?

A6: This is not our preference. In order to consider a client/server architecture, a detailed migration plan, including dates when a .net architecture would be available is required. This plan would need to be included in the contract with monetary penalties assigned for each day after the deadline was missed.

Q7: Please elaborate on the Transmittal of Orders requirement #5: 'Provides ability to trigger medical necessity criteria.'

A7: Desire the system route certain orders (or orders by a specific provider) and direct them to a provider for medical review and approval prior to sending the order to the entity that will fill or complete the order.

Q8: Please provide Washington State standards for referral format CHITA.

A8: Copy of the form below:

*** NOTE: THIS REFERRAL REQUEST DOES NOT GUARANTEE PAYMENT. SERVICES DOCUMENTED ON THIS REFERRAL FORM MAY REQUIRE PLAN REVIEW. PLEASE CONTACT THE INSURANCE CARRIER TO VERIFY THE PATIENT'S ELIGIBILITY AND BENEFITS. AN INCOMPLETE**
FORM MAY RESULT IN DELAY OF PROCESSING.

STANDARD REFERRAL FORM

Referral Provider Name At Clinic/Facility/Name m Please Call Patient to
To Schedule Appointment
Telephone Number Specialty # of Requested Visits m Patient to call
- -
Referral is good for _____ months from Other Considerations
m Appt. Date:_____
referral date Time:_____
Patient Last Name First Name MI DOB MM/DD/YYYY
Information
m Male Member ID # Patient's Contact Phone Fluent Language if Not English Interpreter m Yes
m Female - - - - Required? m No
Parent / Legal Guardian Last Name First Name MI Contact Phone
Subscriber's Last Name First Name MI Subscriber's ID #
Provider Network Primary Health Plan Product Name Plan's Assigned Number Secondary m Yes
Coverage? m No

Clinical Findings Enclosed Available at:

Lab _____ o _____
X-Ray _____ o _____
Chart Notes/Letter _____ o _____
Diagnostic Imaging _____ o _____
Other (specify) _____ o _____

Signature Date
Reserved for Provider Office Use X
Referral Provider Last Name First Name MI UPIN Patient's PCP Name (if not referring provider)
From
Tax ID# Contact Person's Name Telephone Number Fax Number
- - - -
Date Referred:_____ m ROUTINE m URGENT m EMERGENCY
Action Requested: m **Consult Only** m **Evaluate and Treat** m **Assume Management**
m **Itemized Services** m **Evaluate and Treat - Surgery if Indicated**
o Restrictions _____
Reason for Referral: _____
_____ Diag. Group: _____
_____ ICD9 Code:_____
Instructions, Procedures and ITEMIZED SERVICES: _____
_____
o Office Procedure _____ o OB Care _____
o DME _____ o Home Health _____
o Therapies _____

Q9: Please define the terms “problem” and “diagnosis” as used in the RFP relative to the County’s business practices.

A9: A Master Problem List is maintained as a critical element within the Medical Record. This presents information on the condition of the inmate that influences their medical care. The problem could be a diagnosis or a condition like “homeless”. Diagnosis follows ICD-9 code. Vendor should show ability to update consistent within industry standards.

Q10: For those situations where an inmate is allowed to possess KOP medication, is there specific or unique state or county requirements for the instructions associated with the medication? If so, what are those requirements?

A10: Consistent with Washington State Board of Pharmacy requirements JHS is to provide written material (patient education) along with all KOP and property meds. Desire to have the system print the material automatically.

Q11: What percentage of the average daily population is considered inpatient?

A11: None. We do not require an Inpatient (i.e. Hospital) module. Our intent is:

1) *Inmates would be referred to Harborview, UW, etc. A referral would be entered, or interfaced, into the EHR.*
2) *The referral would be accepted (or maybe denied). The referral would be updated, either manually or ideally via interface, in the EHR.*
3) *When inmate leaves the facility, DAJD system updates EHR (worst case manually enter data into EHR).*
4) *When inmate returns, DAJD system updates the EHR (worst case manually entered into the EHR).*
5) *For Hospital Admissions, we would either by interface or manually, enter length of stay information including but not limited to: date of admission, date of discharge, reason for admission, primary physician.*

Q12: What is the recidivism percentage relative to the annual number of intakes?

A12: This information is not available.

Q13: Regarding Page 52, 3. Ability to support WA State standardized referral format (CHITA); Is this another interface? Or is this a form that is filled out?

A13: Ideally, an interface, but at a minimum the ability to print/fax the form.

Q14: Regarding Page 53, is this the admission to the jail? To an outpatient facility (Harborview or Valley)?

A14: ADMISSION refers to intake into the jail and in a program context into one of the JHS programs or services like Infirmary, Family Planning, etc.

Q15: Multiple questions concerning scheduling but we were assuming scheduling would continue to be provided via Signature.

A16: Ideally scheduling would occur within the EHR (or an integrated module). We will need to determine if an interface to Signature is necessary. Refer to A20 of Addendum 2 regarding our approach to interfaces.

Q17: How many outside providers treat patients in the Jails? Will they need remote access to the system (via the Web?)

A17: For providers on-call; for referred to providers in the Harborview systems and potentially other community p, it would be desirable for them to have web based access.

Q18: Details of current network architecture, including schematics if possible. Location and capacity (size) of data closets also needed.

A18: Our expectation is to work with the EHR vendor and County staff to ensure the network meets our requirements. Once this thorough review has been completed, deficiencies will be recommended to the HEHR Steering Committee.

Q19: Are target facilities currently wired with CAT-5 Ethernet, and if not, who is responsible for wiring of the facilities?

A19: To our knowledge our facilities are CAT-5. We will confirm this as part of our Network review as stated in A64.

Q20: We would be obliged to know whether the use of Attachment H is mandatory for the response. The format of the Attachment seems awkward for such a large amount of text. We would ask to be able to use a more straightforward (regular page, single column) format that includes each of the headings on Attachment H.

A20: Regarding Attachment H, the evaluation committee does not have an issue if the attachment is in the form of a MS Word document as long as it's "in the same order". Example:

Heading: COMPANY NAME
A. NAME:
B. Address
C. Location

Heading: COMPANY PROFILE & VIABILITY
A. Company Type:
B. Years in B business:

And so on.

Q21: I would like to receive clarification of the Submittal description on page 2 of the RFP. Specifically, I would like to confirm that Attachment A is NOT to be included in the original and three copies of the response, but should only be sent under separate cover. Further, I would ask whether or not Attachment A is to be included on the CD copies.

*A21: Attachment A, as well as the other attachments, is mandatory in the submission. In the case of Attachment A, the submitter must include 1 hardcopy **only** in the submittal package, and an electronic copy on the CD submission.*

Q22: Under Item 13, what does the County you mean by:

13. Ability to efficiently process (i.e. capture, maintain, display, print) data associated with Patient Coverage Display, including the following:
    a. Ability to display Patient Pharmacy Coverage Data.

A22: The ability to capture/display Pharmacy coverage, co-pays, etc. This is a Public Health requirement.

Q23: In respect of the interfaces described in the RFP and in response to question 20 of the Q & A, you have noted that HL7 interfaces are "preferred". Can you please advise as to whether this refers to versions of HL7 prior to version 3 (essentially flat-file transfers), or whether XML-based HL7 standards (as in version 3) are equally acceptable?

A23: Currently we are using HL7 2.2 real-time connectivity for our interface engine. We anticipate being able to support higher levels of HL7 and XML in the near future.

Q24: You have stated a preference for Openlink as the interface standard. Can you please advise as to whether this is in reference to Openlink's database connectivity products, or to Openlink's middleware Product?

A24: Our Health Care Interface Engine is the Seimens Openlink interface engine, not the products by Openlink Software.
http://www.medical.siemens.com/webapp/wcs/stores/servlet/ProductDisplay?storeId=10001&catalogId=-1&langId=-1&productId=63858&catTree=100001,19036,19048,19046,63858